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ABSTRACT

This technical report is part of a series on AIDS/HIV (Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus) and is intended to help link various legal advocacy organizations providing services to persons with mental illness or developmental disabilities. This report focuses on liability issues from worker and client exposure to HIV. General principles of law are applied to findings of liability that might be brought against an agency or facility on claims of negligent transmission between clients or workers in the following situations: failure to provide a safe environment; negligent worker or client exposure; failure to maintain confidentiality; and failure to protect or warn. Agencies are encouraged to minimize their potential liability by policies which include: (1) an infection control policy and implementation procedures; (2) a sexual behavior policy and procedures for counseling and intervening with recalcitrant clients; (3) a record keeping policy and procedures on confidentiality; (4) an HIV testing policy and informed consent procedures; and (5) creation of a professional advisory committee with multi-disciplinary members that include disability attorneys, physicians, social workers, etc. to advise on policy development and ongoing issues. Contains 33 references and 12 additional resources. (DB)

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AIDS TECHNICAL REPORT

HIV Liability & Disability Services Providers: An Introduction to Tort Principles

David C. Harvey, M.S.W.
Curtis L. Decker, J.D.

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National Association of Protection & Advocacy Systems

The National Association of Protection & Advocacy Systems is the membership organization of over 80 Protection & Advocacy Systems (P&As) and Client Assistance Programs (CAPs) located in every State and U.S. Territory. P&A agencies for persons with developmental disabilities (PADD) were created by Congress as part of the Developmental Disabilities Assistance and Bill of Rights Act of 1975 (P.L. 94-103). In 1986, Congress added the Protection & Advocacy System for Mentally Ill Individuals (PAMI) (P.L. 99-319). The Client Assistance Program was created under Section 112 of the Rehabilitation Act of 1973 (P.L. 93-12).

P&As and CAPs are mandated to provide advocacy services through legal, administrative, and other appropriate remedies to protect the rights of persons with disabilities who reside in institutions, facilities, and other locations, and persons being served by state departments of vocational rehabilitation.

P&As and CAPs are increasingly confronting legal, policy and advocacy issues involving adults and infants infected with HIV, and a range of other issues associated with communicable disease policy, sexuality of persons with disabilities, and persons with dual diagnosis of mental illness or developmental disability and drug use. It is the hope of NAPAS that this series of technical reports will assist the field in responding to the newest challenge facing disability services.

Elizabeth J. Bauer
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Purpose of Publication

In 1988, NAPAS submitted a grant proposal to the AIDS Prevention & Service Program of the Robert Wood Johnson Foundation, Princeton, New Jersey, to develop AIDS legal advocacy services through technical assistance to NAPAS members and production of monographs and research articles. NAPAS was awarded a grant January 1, 1989 for one year, together with 54 other grant recipients nationwide.

Published in February 1990, this publication is the second in a series of technical reports on AIDS/HIV legal, policy and advocacy issues pertaining to mental health and developmental services. These technical reports are intended for wider distribution beyond Protection & Advocacy Systems and Client Assistance Programs to the disability and AIDS community, and are designed to help link various legal advocacy organizations in mutually beneficial and cooperative ventures. Although the responses and capabilities of agencies vary throughout the United States, these technical reports may provide assistance to others and can serve as guideposts for other organizations.

Comments and feedback on the usefulness of this technical report are welcome and should be addressed to David Harvey, Project Director, NAPAS, 220 Eye Street, NE, Suite 150, Washington, D.C. 20002, (202) 546-8202.

This technical report was researched and written by NAPAS staff members David C. Harvey, M.S.W. and Curtis L. Decker, J.D. David C. Harvey is the Project Director of the Robert Wood Johnson Foundation AIDS grant. Curtis L. Decker, J.D., is the Executive Director of NAPAS. Ava M. Imhof provided background research for this paper and the authors wish to acknowledge and thank her for her contribution. The authors also wish to thank the NAPAS AIDS Advisory Committee for review of initial drafts.

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HIV Liability & Disability Services Providers: An Introduction to Tort Principles

David C. Harvey, M.S.W.
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In this current climate, providers of mental health and developmental disability services are concerned with how to minimize liability for worker or client exposure to HIV infection. For advocates of Protection & Advocacy Systems, and other advocates in AIDS service organizations working to ensure individual client rights are not abridged, the need to respond to this issue has been urgent. The central dilemma is how to avoid liability and balance the duty to protect others from harm, while protecting individual civil rights. Service providers are concerned that this dilemma has not been adequately addressed regarding persons who may be mentally incompetent.

This paper gives an introduction to legal theories of negligence and civil statutes that will give service providers and advocates a background to liability issues. Strategies for developing policy specifically in the areas of education, infection control practices and confidentiality are discussed. Having these policies in place and implemented, may minimize findings of liability in cases involving transmission, and protect client rights.

Epidemiology

A recent study released by the U.S. General Accounting Office (1989) reviewed existing national forecasts of cumulative AIDS cases and concluded that a "realistic range" of between 300,000 and 485,000 persons with AIDS will be diagnosed by the end of 1991. These figures are higher than what had been previously estimated by the U.S. Centers for Disease Control (CDC).

As of December 1989, 1,947 children with AIDS under age 13 were reported to the Centers for Disease Control (1989). It is estimated by the Public Health Service that there will be 3,200 cases of pediatric AIDS by the end of 1991, with at least 10,000 to 20,000 children with asymptomatic HIV infection in the U.S. by 1991 (Morgan & Curran, 1986). Further, it is estimated that in the next five years, HIV may become the largest infectious cause of mental retardation and encephalopathy in children under age thirteen (Diamond & Cohen, 1987).

There are currently no scientifically based prevalence studies of HIV among persons with disabilities. Harvey and Elliott (in press 1990), found that of 85 state and county mental hospitals across the country responding to a twenty item questionnaire, most report some in-patients with HIV infection. Staff reported that these patients raise difficult patient management issues, and that the CDC guidelines on prevention of HIV in hospitals does not address the circumstances of sexual and violent behavior that can happen in state mental facilities. Other studies describe the provision of services to adults with mental retardation who acquired HIV (Kastner, Hickman & Beelenhumeur, 1989).

A recent study by Marchetti, Nathanson & Kastner (1990) found state developmental disability agencies reporting that AIDS policies adopted by states varied considerably. Only 10 out of 44 states responding to the study conducted AIDS prevention for their clients, with such training more likely to be provided in institutions. Eleven states reported persons with developmental disabilities who acquired HIV infection, and several states reported some form of segregation of these individuals. Twenty five states responded that information on AIDS is provided in staff training curriculum, with such training more likely given to institutional staff than community agency staff.

HIV Diseases

Knowledge of the clinical course of HIV infection has developed rapidly in the last few years. The Centers for Disease Control developed initial definitions of AIDS in 1982 and then revised the criteria for diagnosis in 1987 (MMWR 35, 1986; MMWR 36, 1987). A diagnosis of AIDS includes the presence of opportunistic infections and malignancies. In 1987, Dementia and wasting syndrome were included in the criteria for diagnosis. Many persons with HIV experience clinical symptoms and abnormalities that indicate the presence of disease but do not meet the CDC definition of AIDS or AIDS Related Complex (National Academy of Sciences 1988)

Of specific urgency for mental health and developmental service providers are symptoms of HIV infection of the brain which can include regressed behavior, apathy, social withdrawal, depressed mood, and some organic psychosis. As HIV brain diseases progress, the person with AIDS may have moderate or severe dementia that can include psychomotor retardation, total persistent organic psychosis, and severe motor weaknesses (Bridge, 1989; Rubinow, et al., 1989). Central nervous system (CNS) dysfunction in infants and children with symptomatic HIV infection ranges from 78% to 90% in various studies. The presence of HIV in CNS may produce progressive encephalopathy, experienced by loss of developmental milestones, intellectual deficits, impaired brain growth, other symptoms and death (Diamond & Cohen, 1989).

Psychiatric research and literature journals have begun to deal in depth with mental illness caused by HIV, as well as presentations of HIV in state mental facilities (Horwath, 1989). Mental health services will be increasingly challenged to distinguish the cause of mental illness as resulting from HIV infection or organic syndromes.

HIV Transmission

Blood, semen, breast milk, and vaginal secretions have been implicated in HIV transmission. Studies show that HIV transmission can occur only through significant exposure to infected blood (through transfusion of contaminated blood or blood products, use of contaminated needles or syringes in IV drug use, needlestick injuries), sexual contact, perinatal transmission, and transplanted tissue or organs from an infected donor (Friedland & Klein, 1987).

Concern has been expressed by developmental and mental health services in situations involving bites. There have been no documented cases of HIV transmission through bites, and studies have shown that bites are not an efficient means of HIV transmission (MMWR, June 23, 1989, Rogers, et.al., 1990). One mental health institution reported anectdotally that some patients have had blood present in their mouths when bites have occurred. The risk of transmission through this means probably remains minimal however, since significant exposure to infected blood or semen through open cuts in the skin, tissues, or mucous membrane is required.

Future Policy Issues

HIV presents a formidable challenge to providers of developmental and mental health services. Increasingly, residential, habilitative, rehabilitative, child welfare and social services, health care and educational services designed to treat and care for persons with developmental disabilities will be forced to confront a new population of developmental disorders caused by infection with HIV. Persons entering developmental services with HIV, or the later stages of infection that results in a diagnosis of AIDS, will be of all ages that include infants who mature with developmental delay, to the adolescent or adult with developmental disability who acquires HIV through high-risk sexual activity or IV drug use.

Mental health services will be increasingly impacted by the adolescent or adult with chronic or severe mental illness who at times may have impaired judgement and because of possible accompanying high-risk behavior, may be at increased risk for HIV transmission. Mental health services include large state facilities, community mental health centers, rehabilitative and vocational day programs, and community residential services. Little is known about the etiological consequences of HIV infection in persons already diagnosed with mental illness, or about the interaction of drugs used to treat HIV and psychotropic medications.

Concerns about HIV have highlighted existing disability service issues involving infection control procedures and whether disability services adequately implement them, sexual behavior within facilities, confidentiality and duty to protect, placement of clients in community settings and the least restrictive environment, and management of the non-compliant or recalcitrant client. New issues regarding the Centers for Disease Control (MMWR, June 16, 1989) call for early HIV testing and access to treatment may have particular ramifications for persons with disabilities under state guardianship.

Fundamental to our society is the notion that every person is responsible for his or her wrongful conduct, and that penalties are accordingly assigned to wrongful acts that result in damages or injury to persons or property. An exception to individual responsibility is a determination of legal incompetence (which includes children under the age of reason).

A tort is a wrong causing personal injury or damage. This body of law protects the legal rights of individuals (Wright, 1944) who have been wronged. The same wrongful act can be a tort (personal injury) or crime (a wrong against the State as defined by civil law).

The theory of negligence has most often been the basis for determining tort liability for the transmission of any communicable disease, sexual or nonsexual. Negligence is defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm" (Keeton, et.al., 1984). This extends to situations involving an act or an omission to act when there is a duty to do so, and where there is a risk of known consequences that are sufficiently great to lead a reasonable person to anticipate and guard against those risks.

The standard of conduct required to avoid liability, usually referred to as the "standard of reasonably prudent person", is that kind and degree of care, which "prudent and cautious men" would use, such as is required by the urgency of the case, and such as is necessary to guard against probable danger (Brown v. Kendall, 1850).

Generally, in order to establish negligence, a plaintiff must demonstrate: (1) a duty or obligation and risks; (2) defendant's breach of that duty; (3) a causal connection between the conduct and the resulting injury. This is what is commonly known as "proximate cause"; and (4) actual loss or damage resulting to the defendant (Keeton, et.al., 1984). Professionals should have a heightened sense of responsibility and will be judged according to standards of their professions and peers.

Three doctrines of negligence discussed below help explain possible institutional or agency liability for HIV transmission. These doctrines should be used by service providers to learn that risk of liability for HIV transmission can result from: (1) an agency failing to adopt or implement policy based on standard scientific and medical knowledge; and (2) employees failing to adequately implement and carry out agency policy.

Negligence of the Employee and Respondeat Superior

Principles surrounding employer or employee negligence suggest that even where employers take appropriate steps to provide education and develop policies, employers are under an obligation regarding their employees' actions. If employees fail to abide by agency policy, the agency may be liable for negligence.

More specifically, the doctrine of "respondeat superior" holds that generally, employers are accountable for their employees' torts committed in the ordinary scope of their employment (Keeton, et.al., 1984). The traditional definition of an employee is a person employed to perform services in the affairs of another, whose conduct in the performance of the service is controlled, or who is subject to a right of control, by the other.

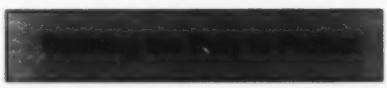
The vicarious liability of an employer, for conduct which is in no way his or her own, extends to all tortious (injury-producing) conduct of the employee which is within the "scope of employment". Subsequently, an employer may be held liable for the actions of employees who fail to uphold standards of care that result in damage to others, even if the employee acts in a manner that was prohibited by employer practice or policy.

Negligence of the Employer or Corporate Negligence

An employer may be liable for any negligence of his own in connection with work performed. Where there is a foreseeable risk of harm to others unless precautions are taken, it is the employers duty to exercise reasonable care to select a competent, experienced and careful employee to provide for such precautions as reasonably appear to be called for. So far as the employer gives directions for the work, furnishes equipment for it, or retains control over any part of it, the employer is required to exercise reasonable care for the protection of others, and must put a stop to any unnecessarily dangerous practices of which the employer becomes informed.

For example, it is the employer's responsibility to monitor implementation of infection control guidelines by staff, and if staff fail to adequately implement these guidelines, the employer could be found liable. Therefore, employers would be well advised to check infection control guidelines to provide for staff education, implementation, and to conduct follow-up training.

The doctrine of corporate negligence has greatly expanded hospital liability. Under this doctrine, hospitals may be liable if they fail to ensure the competence of health care providers, and/or to properly supervise the care provided. The doctrine of corporate negligence does not make hospitals absolute insurers of patients' health, but it does require that hospitals create committees to ensure that treatment is proper, and to review the competence of each individual staff member (Hermann & Gorman, 1987). Several jurisdictions have held that a hospital's duty to supervise extends not only to all physicians and health care providers, but also extends to independent health care workers administering medical care within the institution.



Considerations regarding liability for negligent exposure to HIV is also related to conformity to a standard of reasonable care to avoid foreseeable harm. Avoiding foreseeable harm involves defining a duty to act on behalf of individuals who are in danger. The finding of a duty is an inexact process requiring the balancing of many factors that include (1) the nature of the relationship between providers of service and/or clients; (2) the potential harm to the victim; (3) the foreseeability of the risk; and (4) the public interest in deterring the activity in question.

In 1982, a case involving an involuntarily committed adult with mental retardation who suffered injuries in a Pennsylvania state institution, Youngberg v. Romeo (1982), was decided by the Supreme Court. The decision involved a duty of the state to care for and protect individuals within state custody under the Fourteenth Amendment to the U.S. Constitution. Individuals with mental retardation, voluntarily or involuntarily committed to a state institution, have a constitutional right to live in reasonably safe conditions, and be free of undue bodily restraints within that institution.

Other courts have interpreted the fourteenth amendment as guaranteeing the right to safe conditions in institutions as encompassing adequate food, clothing, shelter, medical care, dental care, and supervision, as well as protection from dangerous situations, such as slippery floors, crowding, harmful noise levels, and safety from attack from others (Society v. Cuomo, 1984). Since developmental disability or mental illness can affect judgment and the ability to protect oneself, providers may have an obligation under the Fourteenth Amendment to protect clients from the transmission of the HIV virus from or to other clients (Rennert, 1989).

Service providers should also be aware that many state constitutions provide similar protections for persons with developmental disabilities or mental illness.

Duty to protect has been interpreted to require that agencies and staff must take all necessary steps which do not unduly infringe on client liberties in order to promote prevention activities and minimize transmission of communicable diseases. Sex education programs should teach safer sexual practices and provide access to condoms and spermicides.

Although the law generally requires disability service providers to protect the confidentiality of their client or patient's medical information, disability service providers may have a competing obligation to protect or warn a third party from harm, and failure to do so could bring liability for negligence. A client or worker of an agency or institution could recover damages for negligence if the breach of duty directly and proximately (closely related in time, space, or order) causes an injury resulting in actual damage.

A physician has a duty to protect third parties from physical harm by warning specific individuals at risk that the patient has a contagious disease, if, according to the Restatement (Second) of Torts (1965) (a "restatement" is a generally accepted explication of the

law and often persuasive to courts): (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or (b) a special relation exists between the actor and the other which gives to the other a right to protection. In addition, some states permit disclosure of information by physicians under certain circumstances (Rennert, 1989).

More specifically, as a result of Tarasoff v. Regents of the University of California (1976), the California Supreme Court imposed a duty to warn on psychotherapists in order to protect third persons from potentially dangerous acts of clients. This doctrine has been adopted in New Jersey, Nebraska, and Vermont. This is further clarified in U.S. v Louis Markus (1984) when:

1. The third person is foreseeable victim or within a class of foreseeable victims.

2. The defendant has knowledge of a specific danger to the victim.

3. The defendant possesses special skills which would enable it to recognize the danger.

4. The defendant stands in some professional relationship to the dangerous person or condition which arises from defendant's special skills.

5. The defendant has some measure of control over the dangerous person or condition, which the defendant in his professional capacity could exercise to prevent the harm.

Accordingly, the law in some jurisdictions, imposes obligations on physicians and therapists because of their unique position, due to their training, experience, and relationship with their patients, to foresee harm to third persons and to take steps to prevent harm. The physician or therapist does not need to have a personal relationship with the third party who could be hurt.

Generally, the physician's or therapist's duty to protect others is limited to identifiable victims - persons known to be at risk of injury. There is no duty to protect the general public; a physician's or therapist's duty to protect others may be triggered when the patient poses a serious risk of danger to specific persons (Rennert, 1989).

Whether a similar legal duty could be imposed on other types of professionals - educators, social workers, attorneys, counselors -remains unclear. It is not clear that a teacher or attorney would be considered to have the same type of relationship, or extent of knowledge, as a physician. As to social workers or counselors, the duty may be extended, as they share the same unique relationship as those more broadly designated as psychotherapists, where clients may disclose specific and detailed information.

This area of the law remains controversial. Advocates fear that agencies and their consulting physicians may breach confidentiality in response to fears of liability and possible harm to third parties. This breach should only be considered in extreme circumstances after all other options are employed. Breaches of confidentiality and warning of third parties may need to be considered by a judge in a court of law before any actions are undertaken.

Problems of Proof

In cases involving alleged transmission of HIV infection to workers or clients, the plaintiff in a case must convince the judge or jury that his or her injury was caused by the defendant's conduct. In the case of HIV infection there may be serious problems of proof (Hermann, 1988). The virus may lay dormant in a person for years. It is therefore often difficult, if not impossible, to determine how long someone has been infected prior to the discovery of positive antibody status or the onset of AIDS and lesser HIV illnesses (ABA, 1988).

Additionally, there may be an obstacle posed by the very nature of the disease in relation to the statute of limitations. A statute of limitations is a time requirement for bringing a cause of action or criminal prosecutions. Determining when the damage is sustained in the case of HIV is complex because of current limitations of technology. HIV antibodies may be not be detected by standard blood tests for some time, and it is difficult to prove when and if HIV transmission occurred in a single incident.

Providers of services should be aware that some states have enacted AIDS specific legislation and, more commonly, regulations which permit public health officials to isolate "recalcitrant" persons who continue to engage in high-risk behaviors (State AIDS Policy Center, 1988). Less restrictive measures also adopted by some states can include compulsory eduction, counseling, testing, medical treatment, and cease and desist orders (Rennert, 1989).

All states, under their police power, have the authority to combat dangerous communicable or infectious diseases by taking reasonable steps to restrict a person's freedom of movement or association (AIDS Policy Center, 1988). Public health officials have long been granted reasonable discretion in imposing measures they deem necessary to protect public health (ABA, 1988; Parmet, 1985). Two such measures are quarantine and isolation. Quarantine means confining persons exposed to a contagious disease for the duration of the usual incubation period; isolation refers to the separation of infected persons from others during periods of communicability.

State authority to isolate citizens for public health purposes may be found in existing public health laws; communicable disease (CD) control laws or regulations. Almost all states have isolation or quarantine authority for individuals infected with communicable diseases, while a third are able to isolate or quarantine if a person is suspected of being infected (AIDS Policy Center, 1988). As of February 1988, twelve states had added AIDS, by statute or regulation, to the list of communicable diseases, and seven states had interpreted their STD regulations to cover AIDS. States continue to enact or revise legislation on public health measures related to communicable diseases.

It is not currently known if these extreme public health measures have been used to any extent to restrict the behavior of a person with a mental disability who may also have HIV. Some advocates fear that these measures may be unfairly applied to persons deemed mentally incompetent.

Discussion: Agency Policy

To minimize claims of liability and to protect client rights, advocates and service providers should consult the following:

(1) Publications from the U.S. Centers for Disease Control on "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (1989), U.S. Department of Labor and Department of Health & Human Services (OSHA) notices, "Protection Against Occupational Exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV)" (1989), the "Joint Advisory Notice" published by DHHS and the Department of Labor (1987), and other publications on infection control policy.

(2) Individual legal counsel retained by each agency or facility, or consultations with Protection & Advocacy legal services.

(3) Individual medical counsel, specialist in infectious diseases, or behavioral consultant retained by each agency or facility.

(4) State civil laws on reporting STDs and police powers of public health agencies.

(5) State public health officers.

(6) Additional resources referenced at the end of this paper.

Based on the documents and individuals mentioned above, each facility and agency should develop a written policy that outlines compliance requirements of staff and residents with the CDC universal precautions and infection control procedures and OSHA guidelines, and policy on client sexual behavior. This will include administrative procedures, training and education, work practices, personal protective equipment, and record keeping.

Other procedures will include confidentiality of records and how information on infectious diseases will be maintained. Specifically, other areas for service provider policy and guidelines include the following:

(1) Management of high-risk situations by clients or staff within facilities.

(2) Management of recalcitrant behavior by clients or procedures for reporting recalcitrant behavior to client's physician, and noncompliance with standards by employees that include procedures for removal from employment.

(3) Creation of professional advisory committees within one agency or a group of agencies that contains multi-disciplinary members that will advise on policy and ethics.

(4) Detailed record keeping that documents all activities with staff and clients on administrative procedures, training and education, work practices, personal protective equipment, and record keeping.

Discussion: Worker Protection

The OSHA guidelines provide detailed administrative procedures for determining effective procedures for workers. The first step involves evaluating the work place to establish category of risk classifications for all routine and reasonably anticipated job-related tasks. After classifying possible situations that may involve contact with bodily fluids, the development of standard operating procedures that include mandatory work practices and access to protective equipment should be implemented. Monitoring of effectiveness of work practices and protective equipment needs to be regularized. With some classifications, gloves, goggles, surgical masks, gowns, etc. should be available. Adult residential services may have less contact with bodily fluids but should have procedures for emergency type situations with access to protective gear readily available. These procedures may reduce claims of liability from worker exposure.

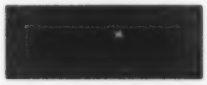
Some service providers have speculated that mandatory HIV testing of clients or workers may relieve agencies of liability claims because identifying and giving special treatment to those with HIV will reduce chances of negligent exposure. Issues of cost associated with repeated HIV antibody testing and the latency period in detecting infection with HIV must be addressed. Mandatory testing may also raise U.S. Constitutional issues, especially under the Fourth Amendment, lawful bodily "search" issues, state constitutional issues, laws governing informed consent, and issues of informed consent under state laws and regulations regarding blood tests (Feldesman, Mandel, Pearl, 1989). Other issues include privacy tort issues.

Discussion: Client Protection

The CDC recommendations provide guidance on testing of patients that may provide assistance in management and diagnosis. Testing is not a means toward universal infection control, however, since the presence of HIV may go undetected, psychological trauma can often accompany the discovery of HIV seropositivity further exacerbating developmental disability and the capacity to act safely, and the risks of discrimination may be profound. If testing is suggested, the following must be obtained: informed consent, pre- and post-test counseling, confidentiality and assurances of nondiscrimination. Procedures to handle crisis situations involving an ethical duty to protect of a client's seropositive status should be outlined in the context of state laws and regulations, and upon the advice of the professional and interdisciplinary advisory committee of staff, physicians, local public health departments, and Protection & Advocacy Systems. Situations involving reporting to physicians, adolescents or adults with developmental disabilities who are recalcitrant will be extremely rare after all other options are utilized.

Consensual sexual activity is another area of policy concern. Programs should have the capacity to assess a client's likelihood of engaging in safer sexual activities with protective devices; the client's understanding of high-risk activities; the client's ability to cooperate with infection control procedures, safe sexual behavior that includes protective devices (condoms), and an ability to control high-risk behavior. Programs should discuss duty to protect issues with the advisory and interdisciplinary team committee, and consult with Protection & Advocacy attorneys.

Policies on HIV testing should consider the discussion presented under worker protection.



As a conclusion to this paper, summarized below are public policy affirmations on liability that were developed following a working conference on "Issues and Public Policy in Developmental Disabilities and HIV Infection" (Crocker, et.al., 1988), held in Bethesda, MD, November 9-10, 1988. These policy statements were endorsed by physicians, social workers, nurses, attorneys, and advocates who provide developmental disability services from across the United States, and may be helpful to both mental health and developmental disability service providers as background information.

1. "Programs providing services for persons with HIV infection and developmental disabilities shall not let liability concerns interfere with the delivery of services to their clients. Lack of knowledge and uncertainty can provide a barrier to this resolve. Agencies shall develop specific policies and procedures to reduce the risk of liability."

2. "No providers, whether private or public, shall discriminate against a person who is HIV infected. Anti-discrimination provisions shall be strengthened in state statute to extend jurisdiction to private service providers. Liability concerns will be reduced when all providers are on equal footing."

3. "Service providers shall maintain accepted standards of least restrictive alternative, normalization, autonomy of choice, privacy, and integration. Policies for clients with HIV infection shall be established which relate directly to the organization, are specific for the clients served, and are consistent with accepted professional practice regarding behavior, mental status, etc. These shall be reviewed periodically and maintained in a fashion consistent with current scientific knowledge."

4. "Individual states, and the federal government, shall monitor provision of insurance to providers, in order to identify and analyze liability risks, minimize and manage risks, and limit individual losses."

5. "Education shall be furnished to all providers, consumers, and insurers regarding the minimal danger which exists for transmission of HIV infection in the setting of developmental services. This will reduce the fear of liability. Also, developing policy guidelines and standards of care will educate staff and reduce the anxiety associated with HIV infection."

Strategies for protective actions to minimize liability and protect client rights includes:

(1) infection control policy;

(2) sexual behavior policy;

(3) record keeping policy & procedures on confidentiality;

(4) HIV testing policy & informed consent procedure; and

(5) creation of multidisciplinary advisory committee.

12

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